KENTUCKY TRANSPORTATION CABINET
Division of Driver Licensing

TC 94-59
Rev. 2/94

APPLICANT:

This form must be completed and reviewed by the Kentucky Medical Review Board prior to your being issued a learner's permit or driver's license. Please complete the first portion of the form and have your doctor complete the second. Return the form to the Division of Driver Licensing for review. Failure to complete the entire form will result in a delay in processing your request.

NAME _____
(First) *(Middle)* *(Last)*

SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

DRIVER'S LICENSE NUMBER *(if any)* _____

ADDRESS _____

_____

DATE OF LAST SEIZURE _____

(Must be completed by you)

DOCTOR:

Kentucky Revised Statute 186.411 requires that we receive the following information on each person suffering from a seizure condition.

LAST BLOOD LEVEL _____ DATE OBTAINED _____

STATUS OF CONTROL _____

DATE OF LAST SEIZURE _____

TYPE AND AMOUNT OF MEDICATION _____

DEPENDABILITY IN TAKING MEDICATION _____

DOCTOR'S NAME _____

ADDRESS _____

_____

DOCTOR'S SIGNATURE _____ DATE _____

THANK YOU,

Medical Review Board
Division of Driver Licensing
State Office Building
Frankfort, Kentucky 40622